The Prevention Connection
NEWSLETTER

The Yellowstone County KMA

—Walt Wagenhals and Melanie Redman

The Yellowstone County Kid's Management Authority (KMA) is one of six grant sites under the state's System of Care SAMHSA grant. The KMA's primary goal is to improve outcomes for kids with Serious Emotional Disturbance (SED) and their families. Traditionally, these families have been served through a patchwork of publicly funded interventions.

The KMA is a local interagency governance team organized to implement a children's system of care and ensure that all available funds and resources are brought to bear to benefit the child and family. Once under the KMA umbrella, families engage in a planning process that includes family members, service providers, interagency partners and the child or youth with an emotional disturbance. Together, this group develops integrated, individualized, strength-based service plans designed to provide clinical, social, educational and other services and supports within the community, in the least restrictive environment possible.

Although the Yellowstone County KMA began building its foundation in 2001 with a cooperative effort that included youth courts, child protection, schools, mental health providers and other child serving agencies, it is now its second formal year of operation under the SAMSHA grant. The statewide SAMHSA grant has further formalized the structure and reinforced Systems of Care (SOC) principles, which are mirrored in state statutes promoting this structure.

Since October 2005, the Yellowstone County KMA has staffed over 100 families. The value of staffing complex cases in a multi-disciplinary team forum has become very clear during that time.

—One boy had been acting out with a lot of physical aggression, tantrums and destructive, volatile rage. The mother's work schedule was a compounding factor: she could not get a routine established for her son. They were living in a single-parent household, with all the attendant household stressors involved in trying to support and parent a challenging child on her own. Their home was chaotic and the mother was worn out. When the KMA team supported a plan for temporary placement in a group home, the mother agreed. The point had come when things had become so broken in the relationship that it was a no-win situation. The boy adjusted well to the group home. The respite benefited both mother and son. The mother needed—and received—support and skills training, and she began to practice setting clear boundaries and exercising consistency. When mother and son were reunited, they were able to start again, at a more stable level of family functioning.

In all care plans established for children with SED and their families, we try to offer a change in family dynamics, a chance to modify parent/child interactions that have become unworkable and entrenched on both sides, while addressing treatment, educational and social needs of the youth.

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Children's Mental Health & Prevention II

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The Vicki Column

This is the second of a two-part series on Children's Mental Health and Prevention. Once again, we were overwhelmed by the response to this topic. You'll notice that this issue is four pages longer than usual, and that it is still absolutely jam-packed with good information.

The parents of children with Serious Emotional Disturbance (SED) will tell you that the stigma is almost as hard to deal with as the illness itself. Children struggling with SED will tell you the same thing. It's no wonder. Our society, in general, feels uncomfortable with mental illness, perhaps because the symptoms manifest through behavior. And while occasionally someone with a mental disorder tips over into splashy violence, it is the exception, not the rule. Most people with mental disorders—children and adults alike—live quietly and invisibly among us, often afraid to reach out for fear of ridicule or worse.

Many other disorders have been treated with great sensitivity by the popular media, but in this case, the media has promoted and underlined the stereotypes. The entertainment industry has fallen back on mental illness as a plot device, to the detriment of the real people struggling with real disorders. These distortions are reinforced by common, discriminatory language. Neither reflect the reality. What they do is separate people into *us* and *them*, creating distance and generating fear.

We hope that these issues of the *Prevention Connection* have shed some light and dispelled some myths. We hope that they have played a small part in reducing the stigma surrounding SED and mental illness. That's an important first step to realizing that there is no *us* and *them*. There is only *us*.

Vicki

Governor Brian Schweitzer: *On Strengthening Montana Families*

I am pleased to have this opportunity to visit with the readers of the *Prevention Connection*.

Affordable, accessible health care has been, and will continue to be, a top priority for my administration. I am particularly concerned about the ability of Montana's working families to provide adequate health care for their children. Senator Max Baucus and I pledged this spring to work hard to fully fund the CHIP program at a level that will insure children whose families have incomes up to 175 percent of the federal poverty level.

Importantly, mental health services for children and youth diagnosed with a Serious Emotional Disturbance recently became available through CHIP in Montana. Additionally, there is great potential in the System of Care approach to meeting children's mental health needs. Working to provide care for families in their own communities makes good sense.

Good health care—including good mental health care—is good business. Dollars spent up-front reward us with tremendous savings down the road. Accessible mental health care for our children and youth is the first step in keeping kids out of the juvenile justice system.

As we look to each generation of youth, it is incumbent on us to nurture leaders, innovators and entrepreneurs, to provide them the personal and community tools needed to learn and grow. The generations that follow are our only hope of meeting the global challenges facing our planet, our nation and our communities.

For those of you engaged in this vital effort to improve the accessibility and quality of mental health services for Montana's children and youth, my sincere thanks. On behalf of all this citizens of Montana, I commend your advocacy and tireless dedication.

Yellowstone County KMA

Continued from cover

— A five-year-old boy was in an acute care unit of the hospital. His symptoms were so profound that it looked as if he would have to be transferred to an in-patient facility outside his community. The KMA assembled a team of professionals who were familiar with the boy, who knew his background and understood the circumstances that had resulted in the escalation of his symptoms. The parent coordinator encouraged the mother to participate in the initial care planning session. The case manager examined the family history as well as the current situation, and went on to evaluate strengths and needs. What was unique in this situation was that the KMA was able to make a paid family support professional available to the mother on a parent-to-parent basis.

There had been points early in this case when the mother was unable to care for her child. Due to some emotional instability and behavioral issues, there were questions about whether she would be able and willing to participate in the care plan. Ultimately, the team worked out a plan to place the child in a local group home. The provider was willing to work with the planning group in order to create an effective alternative that actively engaged the mother in the care and treatment of her son in the group home environment. She recognized that her parenting techniques were critical to addressing her son's needs and made changes.

Often, a temporary break in the form of group home placement can begin to provide the structure needed to help youth reach a higher level of personal responsibility. An alternative setting, such as a group home, can offer a window of time to reshape and reframe how the family fits together.

The services provided in both examples weren't particularly unique, but the focus was intense and the efforts were highly concentrated. In the second case, the effort of the provider was key: by practicing flexibility within its typical structure and protocol, it allowed the parent to practice skills while the child was under their care. Therapeutic efforts in this case meant that therapists and group home staff worked together to provide structure and routine The therapist engaged the child and family therapeutically, while the group home provided structure. Ultimately, the child was able to go home. He's still there, despite the reality of some serious behavioral issues. Ongoing case management continues to identify resources and services. By next year, the hope is that this little boy can participate in a normal classroom environment.

KMAs try to address the individual and unique needs of families, and typically start with a family/child team meeting where a care plan is crafted. In order to succeed, it is important to address the needs of the family as a whole. Many of the recommendations made are based on offering support and skill training for parents. By strengthening the parent's support system and household structure, it is possible to help families begin positively adapting, stabilizing and rebuilding family relationships. The target is always improved quality of life for the child and family.

A System of Care Is:

— child centered,
— family focused,
— family driven,
— community based,
— culturally competent, and
— responsive.

— One youth came to the attention of juvenile probation over repeated instances of shoplifting and other behavioral issues, which were strongly associated with a traumatic history of sexual abuse. This boy's mother had become increasingly challenged by her son's behaviors and was feeling more and more hopeless. During two KMA meetings that included this mother, her parents, the youth on one occasion, school staff and other involved professionals, an integrated service plan was created. Through that plan, the youth was given close supervision through youth court, ongoing mental health case management and counseling for emotional disturbance related to past trauma. Additionally, respite care was set up with support funded through Child and Family Services to diminish the immediate strain the mother was feeling. This family was supported through a coordinated interagency care plan that allowed the family to remain intact in the family residence

A System of Care approach works. The challenge will be in convincing stakeholders that KMAs are not just a financing mechanism, but a qualitative shift away from business as usual. We are always looking for promising results. The results coming from the KMAs are very positive, even though every story isn't a success story.

The core message is that we have to move beyond conventional approaches in all sectors of working with families. We need to see the family's needs in perspective. We have to be available on their terms, and offer value to their efforts to tackle the extraordinarily difficult challenges inherent to parenting kids with serious emotional disturbances.

Here in Yellowstone County, the mindset is changing. More and more we're talking in terms of comprehensive, integrated services, and about the best interests of families and kids. This isn't about running kids through a system. It's about quality and about providing an enriching forum. The touchstones are shared decision-making, shared risk taking and accountability. The rewards can be enriched lives and successful outcomes.

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For more information about the System of Care & KMAs, see pages 12-16.

A hundred years from now it will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove . . . but the world may be different because I was important in the life of a child.

—Forest Witcraft

Notes from the Edge

—Stephanie

Mental health and youth: what does that mean? In the old days, in my Indian culture, mental health included a mental, physical, spiritual and emotional support system that had protocol and guidance when issues would come up within that structure. Our people worked together, no one was more important than any other. We were one. In today's world, our people suffer the repercussions of the many attempts at destroying our cultures. We are left to pick up pieces of mangled cultures that over time have become distorted.

This is my story. Growing up on a reservation in North Central Montana was as dysfunctional as possible. Waking up or going to sleep to a "party" in the other room was "normal." How did I deal with it? Camaraderie. My brothers and sisters were always with me, and a plethora of cousins and other relatives my age were in the same boat. The chaos seemed to roll off of us. We had each other and that is all that mattered. We were in a war zone; we worked to survive. Our best defense was staying as far away from danger as possible, but still within sight of our caretakers because others—people outside the family—were not to be trusted. Though some of us managed to protect ourselves, we did get raped, molested and assaulted.

Dealing with the memories and self-destructive ideology and behavior led me to drink and to drug. And drink and drug I did, for many years. If you wake up and start thinking of the past; it hurts too much . . . so get a drink, quick! Maybe it will go away . . . maybe the drinking and drugging with make it go away, or maybe I will just go to sleep tonight and not wake up. Suicide was too much of an effort—I couldn't put down the drink or drug long enough to fulfill my desire to die, until one night.

Mental health was lying in a dark room with blue walls, popping sleeping pill after sleeping pill, chasing them with vodka. No one cared. No one would notice. I laid there disoriented until I quietly fell asleep, praying. If I woke up, I promised the Creator that I would get help.

I woke up.

At age 16, my stomach was pumped for the pills. I was alone in the cold hospital bed, lonely. I decided that I was never going to get the nurturing and protection I longed for . . . that I would be on my own. I had to find something to live for: I found the bottle. I began slowly killing myself through alcoholism and, eventually, drug addiction. I hit the absolute bottom sitting on a porch on Christmas Day, alone, coming down from alcohol and drugs, unable to sleep, not strong enough to kill myself, not knowing where I was or who I had been with. I had nowhere to go.

After all the suffering, confusion, and dysfunction I came to realize that these experiences had occurred to make me the person I am today. Compassionate, caring, and empowered to do the next right thing.

> ***. . . we will not regret the past, nor wish to shut the door on it . . .***
>
> **—the AA Promises**

These days I find myself remembering what it was like to be eight years old . . . the lodges, the cold water, ashes, the smell of sweet grass, sage, of a fire burning in the woods making the rocks so hot they turned red. The comfort I get from these memories came back to life after I sobered up long enough to wake them up. The longer I stay sober, the more I want peace, comfort and happiness.

For me, mental health has come from within. Through the Creator and my culture, I was able to raise myself up. Not to say that you do it alone, but through the interconnectedness of self and the world, we can overcome any obstacle.

The questions remains; how can we trust the dominant culture? How can we uncurl from the proverbial ball we've been reduced to and seek help? In my experience, it all starts with the "man in the mirror."

Editor's note: the author of this piece says that she is a recovering alcoholic. She is also a hard worker, an important part of her community, a wonderful mother and an incredibly brave, compassionate and caring woman. It is an honor to share her story.

Age at Onset of Child Maltreatment

The age at which a child first experiences abuse may predict the extent and type of psychological problems the child experiences as an adult. Children who first experience abuse as preschoolers may be the most vulnerable as adults.

Using court records, a landmark study included 496 substantiated victims of child abuse and neglect that occurred when the children were 11 years old or younger. Researchers conducted follow-up interviews when the participants were approximately 30 and again at 40.

Results indicated that earlier onset predicted more symptoms of anxiety and depression in adulthood; later onset predicted behavioral problems in adulthood. Maltreatment had the most significant impact when it occurred during the preschool years.

Age of Onset of Child Maltreatment Predicts Long-Term Mental Health Outcomes (Kaplow and Spatz-Widom) was published in the Journal of Abnormal Psychology, Vol 116(1).

Oppositional Defiance Disorder

—Jeri Anderson, LCSW, LAC

Oppositional Defiance Disorder, sometimes called Oppositional Defiant Disorder (ODD), is a highly controversial diagnosis used to explain a pattern of behavior in which teens' or preteens' interactions with authority figures are intensified to the breaking point. Signs include hostility, defiance, aggression, resentment and a low tolerance for frustration. In addition to these signs, a youth with ODD may argue with adults, break rules, blame others for misbehavior and have few or no friends. A central factor underlying this disorder is impaired ability to self-regulate and to cope with routine frustrations.

Signs and symptoms of ODD usually begin to manifest around age seven or eight, but the onset can be as late as 13. To meet criteria for this disorder, the symptoms must persist for more than six months and be more intense or severe than normal childhood misbehavior. According to the DSM-IV-TR, rates of occurrence are higher in boys prior to puberty, but occurrence becomes equitable between the sexes post-puberty. Symptoms are standard for both genders, though males may seem more confrontational. ODD is considered a precursor to Conduct Disorder, but markedly different due to the absence of violence, destructive behaviors and theft.

ODD is difficult to diagnose. Youth vacillate between the symptoms noted above and expressions of affection and co-operation. Consequently, parents may dismiss symptoms as moodiness rather than seek consultation or treatment. Varying definitions of normal childhood behaviors, within cultures and among clinicians, can result in over-diagnosis within some populations and under-diagnosis in others. Given these differences, prevalence estimates currently range between two and twenty percent.

The cause is unknown. Children who experience frequent changes in caregivers and/or who experience neglectful or inconsistent parenting practices demonstrate a greater prevalence. ODD is more common in families in which at least one parent has a history of a mood disorder, ODD, conduct disorder, attention-deficit/hyperactivity disorder or a substance-related disorder.

Treatment commonly involves a two-pronged approach focusing on treating the individual and the family. Individual therapy with a psychologist or licensed clinical social worker is recommended for youth; caregivers are taught behavior modification techniques. Since symptoms are exhibited in a variety of settings including school, additional strategies may be necessary in those settings.

At present, ODD can't be effectively treated with medication, though medication may be prescribed if other disorders are present. Disorders commonly occurring with ODD include depression, hyperactivity and compulsiveness.

The challenges of addressing ODD within the correctional setting are magnified by the increased prevalence within this environment. Pine Hills Youth Correctional Facility is the boy's correctional facility for Montana. In calendar year 2006, 21 youth (32 percent) admitted to the facility carried a current DSM-IV-TR diagnosis of ODD. On average, those youth had received services from four treatment centers/providers before being adjudicated.

Since ODD is considered a precursor of Conduct Disorder, it is not surprising that another 26 youth (40 percent) had a diagnosis of Conduct Disorder, and that five youth were assigned both diagnoses. Of the 21 diagnosed with ODD, four also had an ADHD diagnosis, seven had a substance dependence diagnosis, nine had a diagnosis consistent with a mood disorder and four had learning disorders.

Accurate diagnosis and early intervention are critical. Parents must be skeptical of behaviors that are out of character—and professionals must be willing to listen to caregivers. Accurate diagnosis and early intervention are critical. As a treatment community, we we need to identify co-occurring issues and make referrals as needed. Within the correctional setting, research-based treatment techniques and training must be a priority.

While there isn't a definitive cure for ODD, there are ways of managing the signs and symptoms. Be compassionate, be patient, be consistent, seek professional intervention and, finally, find support for yourself.

Behaviors reported by parents in children diagnosed with bipolar disorder may include:

- *expansive or irritable moods*
- *extreme sadness or lack of interest in play*
- *rapidly changing moods lasting a few hours to a few days*
- *explosive, lengthy, and often destructive rages*
- *separation anxiety*
- *defiance*
- *hyperactivity, agitation and distractibility*
- *sleeping too little or too much*
- *bed wetting and night terrors*
- *strong and frequent cravings, often for carbohydrates and sweets*
- *excessive involvement in multiple projects and activities*
- *impaired judgment, impulsivity and racing thoughts*
- *dare-devil behaviors (such as jumping out of moving cars or off roofs)*
- *inappropriate or precocious sexual behavior*
- *delusions and hallucinations*
- *grandiose belief in own abilities that defy the laws of logic (ability to fly, for example)*

If not treated early, anxiety disorders can lead to: repeated school absences or an inability to finish school; impaired relations with peers; low self-esteem; alcohol or other drug use; problems adjusting to work situations; and anxiety disorder in adulthood.

Attachment: *What it is, how it gets disturbed and what to do about it*

—Elizabeth Kohlstaedt, Ph.D.

Attachment is the relationship between parent and child that assures the child's safety and security. This relationship acts as secure base and allows the child to explore the larger world in safety. Optimally, the attachment relationship—the back and forth dance between parent and infant—helps the developing infant regulate his or her emotional responses to stressors, and serves as the internal model for all subsequent caregiving relationships.

Within the first three years of life, the infant's brain is laying down the neural tracks that will exist for the remainder of his/her life. What happens in those early years determines how the child will respond to stress and change. It is not only the child's internal experience of stress or satiation, but the parent's response to those needs that serves as the filter through which the child views life. If the child had good enough caregiving, and the parents were responsive to needs in an accurate and timely way, the infant learns to tolerate stress, because stress was tolerable in infancy. He can hear *no* and still feel safe and loved. If the child's stress was extreme and/or the response to stress was extreme, the child experiences even minor stress later as overwhelming. That child may experience even small disappointments later as evidence of worthlessness or the precursor to loss or evidence of potential danger. This child may respond to *no* as if it were a life-threatening situation and throw a desk across a room.

Although the foster care system was designed to provide loving homes to children whose families could not safely care for them, it brings with it the potential to make the child's attachment disturbance worse. Repeated moves, either into and out of the birth family in attempts at reconnection, or moves between foster homes, or moves from foster care into adoption, disrupt the fragile, newly forming relationship. The child is more difficult to soothe because the new adults don't know the child's inner world and the newness of the relationship creates anxiety for everyone involved. As children become truly attached to this new set of caregivers, their original template of relationships—that initial attachment—becomes reinvigorated and is placed onto the new relationship. The child becomes more volatile and reactive as he anticipates the frustration, pain and loss of the first relationship, and is harder to understand and soothe than he was when this new relationship didn't matter as much.

Children with attachment disturbances typically give the worst of their disturbed feelings to those with whom they are most connected, and are fine with more distant caregivers, such as teachers, therapists and caseworkers. They typically show more of their disturbance to one parent (usually the mother) than the other. This can be confusing and distressing to the parents and to the child, and can create a wholly unsupportive world for the parents of the child. Others not connected to the child may question the foster/adoptive parents' sanity, intentions or skill.

The soundest approaches to healing these children involve helping the adults see and understand the child's inner world. Children will change their behavior when caring, stable adults see the world from their perspective. It is how we as adults make sense of a child's behavior that allows our interventions to be specific and timely, and therefore effective.

An initial step in viewing the child's inner world is to create a solid, stable structure within the family. This can be difficult in busy lives, but it is up to adults to create opportunities for safe connections. Simply providing affection is not enough for children who have danger, instability and loss wired into their brains. These children need patterned, repetitive experiences of predictable safety and routine in order to feel safe. Age appropriate routines and expectations can be as simple as story time before bed or a quiet talk on a parent's lap before any major transition, including to and from school. It could be some room time or some quiet time with family after dinner.

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Intermountain, established in 1909, serves over 300 children per year in its residential program, day treatment program, adoption and family support program, outpatient psychiatry clinic and community based group homes.

Intermountain's Vision:
Secure emotional health and a loving permanent family for each child.

Intermountain's Mission:
Healing through Healthy Relationships.

Intermountain's Values:
In all that we do, create a supportive environment that promotes healthy change and growth.

Working with others, improve society's ability to provide prevention, protection, treatment and permanency for all vulnerable children.

Attachment

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The important part of structure is to provide a framework within which to deepen a relationship. It is not an end unto itself, but a way of carving out time to be with the child. This is especially important when the child is new to the relationship, but remains important across time. Dinner time, bed time and morning wake up times are particularly difficult for children new to relationships. At those times, the basic expectation of how to sit and eat, how to relax before sleep and how to get up may remain invariant, but the child may need to be given special help when he is new to the family or when he is anxious. A night light, music, special wake-up or dinner routines designed for the particular child may ease him/her into this new family life.

Another vital piece of structure is making sure that the child slows down when he is starting to become overwhelmed. We want children to pace their emotional responses, and children from chaotic backgrounds may need adults to help them with that pacing. Asking the child to slow down his speech or to take a break in the presence of the adult, or asking the child to sit down and think for a minute, can help the child pace himself. At times, children feel so bad about themselves, regardless of adult affection, that they cannot have fun. At times, playing actively with the child can change the child's depressive rhythm. The adult needs to guide all structure and pacing interventions. Expecting a child to follow an instruction by himself is usually a set up for failure for the child and a disappointment for the adult.

Once the family has established some structure, there is room for the relationship to develop. This takes time and trust. When the child first enters a relationship, trust is low and anxiety high. Only with patterned, repetitive meeting of needs will trust become high and anxiety low. Trust is developed through the child's sense that the adult understands him and can engage in ways that feel good and safe. This takes great effort on the adult's part because the adult is trying to overcome years of the child's experience of not being understood and not being treated well. We can't talk children out of this; we can only behave in ways that are inconsistent with their expectations of harm and rejection. We wouldn't expect to have a fully developed adult intimate relationship within six months, yet often families expect the child to be fully integrated into a new family within this short time.

At Intermountain, across programs—Day Treatment, Adoption and Family Support Program, Residential Care or Community Group Homes—we typically see children respond to structure with behavioral calming within the first six months. Between six months and one year, they deepen the relationship with the new significant other, and between 12 -18 months they struggle with separating their old attachment experiences from the new one. Unfortunately, for children from chaotic backgrounds who have experienced multiple losses and stressors, the deepening of the relationship is often accompanied by increased acting out within the primary relationship. A third party—a therapist, a spouse, a family friend—may be able to translate the child's experience of this fear to the parent in a way that the parent can hear. The child's behavior may create anger in the adult, but if the adult is open to the child's experience and can attune to the child's fear, the behavior will change.

If we can see beneath the child's behavior to his inner experience when connecting, we usually see a longing to be special, to be understood, to be known and to be cared for. With that longing comes fear that all of the previous hurts, losses and rejections will happen again. It is up to us as adults to try to see through the behavior to the fear and longing beneath it and meet those needs in an accurate and timely way.

—Elizabeth Kohlstaedt, Ph.D. is the Clinical Director at Intermountain in Helena.

The Hidden Cost of Adult Depression

When a parent suffers from depression, children are more likely to need costly health services like emergency room visits, and less likely to get preventive healthcare, according to a new study by Dr. Marion Sills and her colleagues at the University of Colorado Health Sciences Center in Denver. The researchers reviewed data on nearly 70,000 infants, children and teenagers. Findings bolster evidence that parental depression can take a toll on their children's health. The effect can be seen as one of the hidden costs of adult depression.

Children with at least one parent diagnosed with depression were more likely than other children their age to have an emergency room visit, see a specialist or visit their doctor due to an illness. Teenagers with a depressed parent were less likely to make routine visits for a check-up and preventive care. At the same time, another study suggests that only about eight percent of pediatricians routinely asked mothers about symptoms of depression.

SOURCE: Journal of Pediatrics, April 2007.

The Impact of Parental Substance Use:
Findings from neurological evaluations

—Mona L. Sumner, MHA, ACATA

—"Every day I am more and more thankful that I am alive and sober and free from addiction. I spent 16 wonderful months in Michel's House and while I was there I learned everything I needed to know about motherhood, sobriety, self worth, addiction, love, happiness and life just to name a few off the top of my head. I learned things in the Michel's House that I don't know where else I would have learned them. I learned priceless lessons and I am grateful, thankful and blessed. I just celebrated 22 months of sobriety with my son." —Michel's House graduate

Emotional dysregulation (or affect dysregulation) is a term used in the mental health community to refer to an emotional response that is not well modulated. This means that an individual does not respond to a person, place, thing, or event in a manner that would generally be considered within the normal range of emotions.

Emotional dysregulation is a broad phenomenon that is a component of many mental health disorders. It is often caused by early exposure to psychological trauma or chronic maltreatment (such as child abuse, child neglect, or institutional neglect/abuse).

Treatment for emotional dysregulation must address the underlying cause. For example, attachment-based treatment interventions may be appropriate for children or adolescents suffering from emotional dysregulation such as is found in Reactive Attachment Disorder or Complex Post-Traumatic Stress Disorder.

Much has been written about the impact of substances on the brain in these last few years, and we have come to recognize addiction as a brain disease. Less is known about the problems that maternal addiction inflicts upon children, born or unborn. We have known, of course about Fetal Alcohol Syndrome, but have not had much exposure to research about drugs other than alcohol. We have been following the children at Michel's House, a long-term residential setting for drug-addicted mothers with children under age 12.

Under a grant provided by the Chemical Dependency Bureau, Michel's House has, for six years, been admitting and treating chronic, severe, drug-addicted women and their children. The average stay is 14.6 months. Mothers attend the in-patient program at Rimrock Foundation during the day, while children are placed in daycare. After about about six months, mothers begin a life skills program designed to prepare them for independent living and employment.

Through neurological evaluations conducted by Dr. Brenda Roche, we have considerable data on children and mothers at the time of admission and at follow-up intervals. It is interesting to note that the children's neurological status nearly mirrors that of the mother at the time of admission. For example, 74 percent of the children have impaired executive functioning, defined as difficulty planning, organizing, managing time and remembering. They may also exhibit delayed responses and difficulty sustaining or shifting attention in order to set priorities in responding to various environmental stimuli. Eighty-nine percent (89%) of the mothers evidence significant impairment in executive functioning. We generally assume the damage to the prefrontal cortex (the CEO portion of the brain) is a function of drug abuse. Thus, it is surprising to find the same high level of dysfunction in the children. These children also present with additional problems, including:

- Language delay disorders;
- Behavioral/emotional deregulation;
- Learning disabilities/delayed school readiness; and
- Attachment disorders.

It is difficult to separate the potential neurological impact of maternal substance abuse from the parental neglect that is a defining characteristic of maternal addiction. In particular, language delays are a common byproduct of parental addiction because addicts do not talk to or interact consistently with their children—and children only learn language from human interaction. Early language delays impact children in multiple ways, including behavioral dysregulation, low self-esteem, poor academic performance and social difficulties. Without early intervention, these children will develop disruptive behavior disorders in adolescence.

The level of language delay often predicts the degree of behavioral dysregulation in Michel's House children. This is where we place the greatest initial emphasis with these children. Each refrigerator has Frigerator Phonix by Leapfrog on it, low enough for children to stand a play and learn sounds. Also located at child height are the traditional faces charts that illustrate feeling words. Mothers contract

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Early Childhood Mental Health

—Christie Hill-Larson

Giant steps have been made in the fields of prevention science and child development. Early intervention, assessment, treatment and support of mental health are critical and can have a significant impact on the lives of children who experience mental health problems at very young ages.

Recently, a great deal of attention has been paid to brain development, early childhood consultation and school readiness. Early childhood programs and providers report seeing an increase in the numbers of children who exhibit behavioral and emotional problems, at younger and younger ages. These behaviors can be the result of abuse and neglect, violence, losses due to incarceration or death, health issues, homelessness, multiple caregivers, and other stressors that affect the well-being of young children.

Early childhood consultants are trained to work with infants, toddlers, preschool children and their caregivers, and are in the best position to help the adults who work with children who have challenging behaviors. Early childhood professionals trained in the early childhood consultation model have a specific skill set and the expertise to provide services in a variety of settings including child care centers, family child care homes, preschools, infant and toddler programs, kindergartens and home-visiting programs.

The goal of an early childhood consultant is to take a comprehensive approach to assisting individuals with incorporating a mental health perspective in their work, while drawing on their own education, skills and experiences. Consultants should have knowledge and understanding of: young children's social-emotional development; superior observation, listening, and assessment skills; knowledge of environments, curriculum, and developmentally appropriate practices; familiarity with heath and safety issues. They also need the ability to work with adults in a wide variety of settings.

The relationship between the consultant and the adults in the program is critical to the success of the consultation model. A large part of the work is interacting with adults, whether the lone family home child care provider, parents or groups of teachers and assistants. A consultant must understand and respect cultural differences and the wide spectrum of quality early childhood settings.

Consultation is a relationship process that has no specific timeline. The consultant may work in a particular early childhood program for a period of weeks, months or even years, depending on the need and the relationships. When a safe, healthy, nurturing and stable environment is established, and when children and adults are valued, everyone benefits.

Early childhood consultation is an effective service that has been in existence in some states for many years. There are many funding sources, private and public, that could support consultation in Montana, and communities are beginning to explore the possibilities presented by this comprehensive approach.

Early Childhood Resources

— *The Center on the Social Emotional Foundation for Early Learning: www.vanderbilt.edu/csefel/*

— *Healthy Childcare America: www.healthychildcare.org/CCHC.cfm*

— *National Mental Health Information Center: http://mentalhealth.samhsa.gov/publications/allpubs/svp05-0151/sec1.asp*

— *Mental Health Consultation in Early Childhood Settings and Child Care: www.cpeip.lsu.edu/resourceFiles/*

The Impact of Parental Substance Abuse

Continued from Page 8

to read to their child regardless of age a minimum of 20 minutes per evening and to get down on the floor and play with them for 30 minutes before beginning a consistent bedtime ritual.

Many of the children catch up with their language skills with this level of effort, while others are placed into language clinics or specialized preschool programs. A parenting program designed to address maternal bonding and to teach skills to address the behavioral dysregulation is ongoing throughout the mother's stay. With these interventions, by the time they leave the program, children show significant improvement and are at average or above-average developmental levels in the following areas: language skills; school performance; school readiness; motor skills; attention; memory skills; behavioral and emotional regulation.

For the most part, the children achieve their milestones faster than their mothers demonstrate improved neurological functioning. Without this type of concentrated intervention however, we would surely have many children of addicts functioning at sub-optimal levels and facing turbulent adolescences.

—Mona L. Sumner is the Chief Operations Officer for Rimrock Foundation·Michel's House. Michel's House is a long-term residential setting for drug-addicted mothers with children under age 12 located in Billings and operated by Rimrock Foundation.

CSCT in Kalispell

—John Brandon

Comprehensive School Community Treatment (CSCT) is a specialized mental health program operating in the school environment. It can be a very effective program, provided that all involved understand how the program works.

Under a contractual agreement with School District #5 in Kalispell, Northwest Behavioral Health (NWBH) delivers CSCT services to students in the elementary and secondary schools on a daily basis, throughout the school year. If necessary, NWBH also provides CSCT support during breaks, holidays and the summer vacation.

There are many rules involved. Northwest Behavioral Health clinical staff are in the District Five schools every day working with clients. This means complying with the State of Montana's CSCT Program Rules, Mental Health Center Rules, Medicaid Rules for School-Based Services, and Northwest Healthcare's Clinical Standards of Care and Employee Guidelines. These are all in addition to abiding by the rules specific to each school.

Rules and policies are designed to help, but can become major challenges to success. At first glance, operating a CSCT program seems complex, given all the policies and procedures involved. The bigger issue with school-based mental health is how to successfully incorporate a medical model of treatment with the academic model. Better yet, how can we best turn the challenges of delivering service in a school setting into opportunities? The CSCT program attempts to resolve this issue by blending the models.

Districts that sponsor CSCT Programs are required to be the Provider of Services—a role normally assumed by Mental Health Centers. Districts can also opt to become Mental Health Centers, if they decide to serve as the provider and deliver services with their own staff. Like Kalispell, most districts prefer to contract with mental health agencies.

At NWBH, our goal is simple: to provide high quality intensive level mental health services to identified children, adolescents and their families within the school setting. To accomplish this, Montana Medicaid has defined most of the operational guidelines in three basic rules. Many of the challenges in day-to-day operations are a result of misunderstandings these rules.

Rule #1: We cannot provide academic services in CSCT. We are not a tutoring service, a homework service or test-taking service. We explain up front to school staff, parents and the clients themselves what we can and cannot do.

Rule #2: CSCT is available to any child, but it must be paid for, either through Medicaid, private insurance or on a sliding fee scale. This is sometimes called the *Free Care Rule*, because if we admit a client to our CSCT program and provide services to that client free of charge, then *everyone* gets the service free of charge.

Rule #3: Each child in the CSCT Program must meet the Clinical Guidelines set by the State of Montana. The child must have observable signs and symptoms over time and across settings, and must meet the criteria for Serious Emotional Disturbance (SED). The child must've had or be receiving some form of intervention from the school or an outside provider. The list of covered disorders includes major depression, post-traumatic stress disorder, oppositional-defiant disorder, and generalized anxiety disorder. The signs and symptoms must have been observed for at least six months and across settings other than school.

On any given day, a CSCT therapist might lead a group therapy session in the morning, an individual therapy session in the afternoon and spend the time between consulting with school staff, outside agencies, seeing parents and dealing with a crisis that may or may not be resolved by the end of the school day. The therapist's team partner, the mental health worker, is no less busy. When a child is a client in the CSCT program, many people can be involved. Communication can become a challenge, but if communication is valued and maintained by that group, the child's opportunities for success are greater in academics and in treatment.

—John Brandon is Clinical Supervisor for Northwest Behavioral Health in Kalispell, Montana.

Evidence-Based Programs

As part of its Science to Service initiative, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently relaunched the National Registry of Evidence-Based Programs and Practices (NREPP), a searchable database of evidence-based practices in the prevention and treatment of mental health and substance use disorders. NREPP allows users to narrow their searches based on target populations, service settings and desired outcomes.

Key features include descriptive summaries of interventions, implementation costs, outcomes, developer contact information and independent expert ratings.

For more information, visit the NREPP website: www.nrepp.samhsa.gov/

Follow the Child in Missoula

—Carol Regel, RN

The *Follow the Child* project in Missoula City-County Health Department (MCCHD) Health Service Nursing Division integrates Missoula County's foster children into existing public health systems of preventive health care and collects retrievable health information that follows the foster child while in the guardianship of Child and Family Services (CFS).

Public Health Nurses (PHNs) have long recognized that children living in an environment of neglect and abuse are not magically transformed into healthy children when placed in the care of a nurturing family or youth home. Many children entering foster care have not had regular medical, dental or mental health care. Once in foster care, a Child and Family Service (CFS) social worker is expected to gather and interpret health information and assess the child's health needs. It makes sense that children with special health care needs (such as foster children), be integrated into an existing public health system that has the experience and skill to assess the child's health and make the appropriate interventions. The PHN also participates in the orientation of new foster parents, which has been helpful for foster parents to recognize the function of this program.

To accomplish this, the *Follow the Child* project has developed a referral system with CFS social workers. The PHN contacts the foster parent or group home for a home visit and provides age appropriate health assessments and referrals. The PHN also provides health education to the foster parents, ensures that immunizations are up to date, assesses knowledge of medications, and assists with WIC enrollment. The PHN collects and summarizes the medical, dental, mental health and school health information, and shares the summary in writing with CFS social workers. This information is added to the child's permanent computer record and a written copy is shared with the child's medical home.

An 11-member advisory committee of consumers and professionals was created to ensure that the project has community input regarding the healthcare needs of foster children in Missoula County. In the past three years of this program, children aging out of the foster care system have been identified as a group at particular risk. As a result, the PHN has developed a protocol that includes education on their health care needs and detailing how to obtain community resources.

Health issues of children in Missoula County are similar to those of children in the foster care system throughout the nation. Infants are being removed because of exposure to methamphetamines in utero. Children aged one to five have eczema, developmental delays, asthma, allergies and ear infections.

Child aged six to twelve are most commonly seen with Attention Deficit Hyperactivity Disorder (ADHD), acute dental needs, allergies, visual, mental health and learning problems. Youth aged 12 to 18 have issues with obesity, asthma, allergies, ADHD, mental health and learning problems. Since this project began, *Follow the Child* has served 244 foster children and has an ongoing caseload of around 150 children.

The *Follow the Child* project is a collaborative partnership between MCCHD and with Child and Family services. It began 2004, when it received a 5-year grant through Healthy Tomorrows Partnership for Children: a collaborative of the Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP).

For more information, contact Health Nurse Project Coordinator Carol Regel, RN at the Missoula City-County Health Department at 406-258-4293 or RegelC@ho.missoula.mt.us.

CHIP for Children with SED

The Children's Health Insurance Plan (CHIP) provides extended mental health benefits for children with a Serious Emotional Disturbance (SED).

CHIP provides low-cost or no-cost health insurance for eligible children up to age 19. The program currently covers nearly 13,300 Montana kids and has openings for about 600 more. CHIP staff estimate that 200-300 children may qualify for these extended mental health benefits.

The basic CHIP Plan covers prescription medications, and limited inpatient mental health services and counseling sessions. The CHIP Extended Mental Health Plan also covers some community-based mental health services: therapeutic group home services (including room and board); therapeutic family services; day treatment; community-based psychiatric rehabilitation and support services; individual and family counseling sessions; and respite care.

In order to receive these specialized services, a child must be enrolled in CHIP, submit a recent psychological assessment with DSM-IV diagnosis to CHIP, and be determined by DPHHS to have a serious emotional disturbance.

If you are providing mental health services to a CHIP child who may be eligible for Extended Plan benefits, visit the CHIP website at www.chip.mt.gov or call 1-877-543-7669.

Mental Health and Juvenile Justice

—Cindy McKenzie

Over the past year or so, Riverside Youth Correctional Facility (RYCF) has seen a noticeable increase in the number and type of psychotropic medications prescribed to the adolescent females entering the facility. The placements described in the sidebar at left reflect the actual prescriptions of adolescent girls recently adjudicated to RYCF.

A few months ago, during a conversation with RYCF's long-term contracted psychologist, we reviewed this increase. We both expressed concern about the types and amounts of medication being prescribed to these adolescents, particularly in combination with their documented histories of illegal substance use. Having worked together for quite some time, we shared the same perception that the adolescent females currently being adjudicated to RYCF are coming to the facility with noticeably increased mental health/substance abuse histories.

As a result, RYCF staff members are finding themselves in the increasingly difficult position of sorting through histories of different diagnoses, different types of prescribed medications, substance abuse, failed placements and illegal behaviors . . . often in that order. Throughout the nation, many correctional facilities are being chastised for not providing appropriate treatment for mental health issues, including appropriate levels of medication. While some of that criticism is warranted, the flip side of the issue, especially in the juvenile justice system, is attempting to determine a true need for the multitude of medications youth come into the facility using. This is particularly challenging because most often, there are histories of sporadic compliance in taking the medications while also using a variety of illegal substances.

It is well documented that the side effects of substance abuse, either when high on drug(s) or coming off of the drugs, can mimic symptoms of depression, anxiety, mania and psychosis. It is a common behavior among chemically dependent people who without access to illegal drugs to request prescription drugs. It is also well documented that those suffering from mental illness will self medicate with illegal substances. The challenge is how to sort this out, to determine an accurate diagnosis and possible need for medication.

If medication appears warranted, it becomes a concern about which medication is appropriate, given the lack of information regarding the effects of psychotropic medications on the adolescent brain. If a serious mental illness does become apparent in a "clean" environment, it is a challenge to sort out how best to move that youth from the correctional setting to a psychiatric setting, particularly since many have histories of failure in those placements.

Correctional facilities are increasingly put in the position of providing the "best" place for a structured/secure mental health assessment. While it is true that one has to commit a crime to be sent to a correctional facility, the nature of many of these crimes does not make the offender a serious threat to the community. At the same time, the nature of co-occurring chemical dependency and mental illness often necessitates the need for locked doors and a good period of time in a structured setting.

Years ago, when I first started in this field, it was possible to send youth to secure care facilities for a 45-day evaluation prior to adjudication. I disagree with that setting, since mixing youth under evaluation with youth who have been adjudicated is often inappropriate. Even so, the concept was, and is, valuable. The lack of good assessment alternatives increasingly impacts the corrections world and communities at large. Hopefully, the need for these alternatives will become more and more apparent, and alternatives to correctional facilities will be developed to provide an appropriate setting for an in-depth mental health/chemical dependency evaluation.

—Cincy McKenzie is the Superintendent of Riverside Youth Correctional Facility in Boulder, Montana.

Representative Prescriptions at Placement

Adjudicated to Department of Corrections, with placement at the Riverside Youth Correctional Facility (long-term secure care for adolescent females), in last year for some type of Possession or Use of Dangerous Drugs charge:

—1st adolescent female: Seroquel 300 mg nightly, Abilify 15mg and Lexapro 10 mg each morning.

— 2nd adolescent female: Abilify 7.5 mg, Strattera 40mg and Cymbalta 30 mg each morning and Clonidine HCl 0.1 mg nightly.

— 3rd adolescent female: Wellburtrin 300 mg each morning and Abilify 5 mg each evening.

Had parole revoked in last year on charges including use of illegal substances:

— 1st adolescent female: Lamictal 100 mg, Seroquel 200 mg & Clonidine 0.1 mg in the mornings.

— 2nd adolescent female: Abilify 5 mg twice daily, Trazadone 50 mg and Seroquel 200 mg each evening.

Montana's System of Care

—Bonnie Adee

Montana values its children and families and works to preserve the welfare of the family, with a focus on keeping families together and well. This was clearly demonstrated when 2003 legislation formalizing a children's System of Care was sponsored by Senator Emily Stonington and passed into law. This legislation, building on an earlier version of the initiative sponsored by Senator Mignon Waterman, provided for the Multiagency Children's Services System of Care Initiative for high-risk children with serious emotional disturbance, and was designed to build state and community capacity to support the appropriate care and treatment of high-risk children in the least restrictive and most appropriate setting.

That said, as a state, we haven't yet developed all of the necessary services and supports for some of our highest-needs kids. It is particularly difficult in a rural environment to provide for children who have a constellation of complex needs, such as developmental disabilities coupled with Serious Emotional Disturbance (SED), or SED with chemical abuse or dependency issues. One of the major barriers to addressing these needs is economy of scale. Often it comes down to the fact that we simply don't have the systemic capacity to serve children with multiple, complex needs here at home. And yet, collectively, these are our children and it is our responsibility to meet their needs.

If we could take a step back to look at the big picture and could pool all of the resources allocated to child-serving agencies, we might have enough resources to serve our highest-needs children. Unfortunately, funding is often tied to labels. Each funding source has its own mission, vision, goals, objectives and regulations, which are passed on to those who receive its funds. The other side of the coin is the social cost of space. In Montana, that cost is high—there is a lot of highway between small towns.

We need to increase the capacity of communities to serve children—to improve collaboration and cooperation among the child-serving agencies. To accomplish that, we need strategic providers willing to offer community-based services.

The vision for Montana's System of Care is a strength-based, comprehensive, individualized, culturally competent system that provides developmentally appropriate care in the least restrictive setting safe for the child, family and community. On a practical level, this means unified care and treatment planning. At the community level, inter-agency teams are the tool to provide that planning and care. These teams, Kids Management Authorities (KMAs), serve to provide infrastructure. Agencies come together in a child- and family-centered model designed to provide comprehensive services in support of families with high-needs, seriously emotionally disturbed children and youth. Family participation is a crucial component to the success of the local and state KMA process.

The initial start-up for community-level KMAs was supported by a Systems of Care grant awarded to the State by SAMHSA (the Substance Abuse and Mental Health Services Administration). The Crow Nation and several cities stepped up and agreed to be among the first to establish local systems of care and to serve help fulfill the evaluation component of the grant. In exchange, they received tools, training and support. When the grant eventually goes away, we hope to be left with a workable model for Montana and a stable system of care. At the end of the day, we anticipate the evaluation efforts will provide clear evidence that this works.

There is a chasm between we know is good and what we know works. To ensure that kids have the very best outcomes, we know that we need to intervene early, and yet the responsibilities of the Children's Mental Health Bureau by necessity are focused on children and youth who need mental health services. The bigger vision is to try to reduce that number, and to help kids earlier. At this point, we're swimming in the deep end, but with the further development of KMAs throughout the state, we can start addressing community issues proactively rather than reactively.

Arthur J. Rolnick, Senior Vice President and Director of Research at the Federal Reserve Bank, looked at high-quality Early Childhood Development for at-risk children through an economic lens. He documented the fact that if done right, high-quality, parent-focused ECD programs that begin at birth make an extraordinary difference in outcomes for children and society. Children are less likely to repeat grades, drop out and run into trouble with the law. The annual rate of return? Sixteen percent, inflation adjusted. The impact on children, families and Montana? Priceless.

Welcome Bonnie!

Bonnie Adee recently accepted the position of Bureau Chief of the Montana Children's Mental Health Bureau. She has earned two Masters degrees: one in Education from Harvard University, and one in Health Services Administration from Central Michigan University. She has a solid background of experience in education, healthcare and public service, and most recently served as the Mental Health Ombudsman for Montana. Ms. Adee was instrumental in conceptualizing and writing the initial System of Care grant for Montana.

VISTA Site Applications

Prevention Resource Center (PRC) VISTA site applications are due in March and September of each year.

Visit the PRC website for details: www.prevention.mt.gov.

KMAs: *The who, what and where*

What is a KMA?

Kids Management Authorities (KMA) provide infrastructure and a comprehensive system of services designed to meet the individual needs of children who have Serious Emotional Disturbances (SEDs) and their families, and to help address gaps in community services by drawing on local strengths. Family participation is crucial to the success of the local and state KMA process. Families are encouraged and expected to participate at the individual team, community team, and state System of Care Committee.

Legislative authority for KMAs can be found in MCA Title 52, Chapter 2, Part 3. At the State level, the System of Care Committee provides direction and oversight to the development of KMAs. The Children's Mental Health Bureau staff has primary responsibility for KMAs, with Program Officers in each region providing support to communities that have, or intend to develop, KMAs.

Who do KMAs serve?

- Children with SEDs who are at risk of, or currently residing in, out-of-home placement. These youths are typically served by many agencies.
- Children under the age of six. Prevention and early intervention services are critical to the long-term success of a system of care.
- Each KMA has the discretion to serve a secondary population of youth based on its ability to do so.

Guiding principles

- A system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services.
- The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
- The system of care should be culturally competent, with agencies, programs and services responsive to the cultural, racial, and ethnic differences of the populations they service.

KMA goals

- Design, implement and support a community-based system of care for youth and families.
- Integrate a wrap-around philosophy with service delivery.
- Reduce the stigma surrounding serious emotional disturbances for individuals and their families.
- Partner with the state to provide information on the system's needs and development, participate in policy development, educate legislators on the needs of youth with serious emotional disturbances and its impact on families.

Primary functions of KMAs

Community teams serve as the gateway to the local system. KMA Community Team representatives create a process for the local system of care. They formalize relationships, identify and create community resources, develop policies and procedures to ensure unified, comprehensive service delivery and to collect and utilize data.

Individual care coordination teams serve individual families. With few exceptions, parents serve as the team leads. The team is comprised of the agencies and individuals involved with the youth and family. The team designs a unified, comprehensive treatment plan encompassing all agencies needed by a family.

Why your agency should participate

- Children with SEDs and their families need a unified plan of care to minimize confusion and maximize resources.
- Information sharing among agencies is easier.
- Services and treatment are based on the strengths of youth and families.
- KMAs can reduce the pressure on partner agencies' budgets, allowing for the transfer of resources to more preventative and less costly services.

Alternative Treatment for Children with SED

Montana was one of10 states to receive a federal grant to help children with serious mental illness get treatment in their homes and communities rather than in residential treatment centers.

The Department of Public Health and Human Services (DPHHS) will get $644,000 in the first year of the 5-year grant, according to Mary Dalton, Administrator of the Health Resources Division of DPHHS.

"This grant is an important step forward for children's mental health," Dalton said. "We look forward to working with families to develop a more compassionate and family-oriented approach to meeting the needs of troubled kids."

The grant will enable development of a comprehensive package of services for Medicaid-eligible youth who, with proper supports, could remain in their homes and communities while receiving treatment. These services may include expanded respite care, family education and/or 24-hour crisis intervention.

The Children's Mental Health Bureau will implement the grant in Yellowstone County the first year, with a goal of serving about 20 children. In the next four years, the department will expand the program to serve children and families in other counties.

For more information, contact Lynn Jennings of the Children's Mental Health Bureau at 406-444-3819.

Children's Mental Health Bureau System of Care Administrative Regions

Region I – Miles City

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Region II - Great Falls

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Region III – Billings

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Region IV – Helena

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Region V – Missoula

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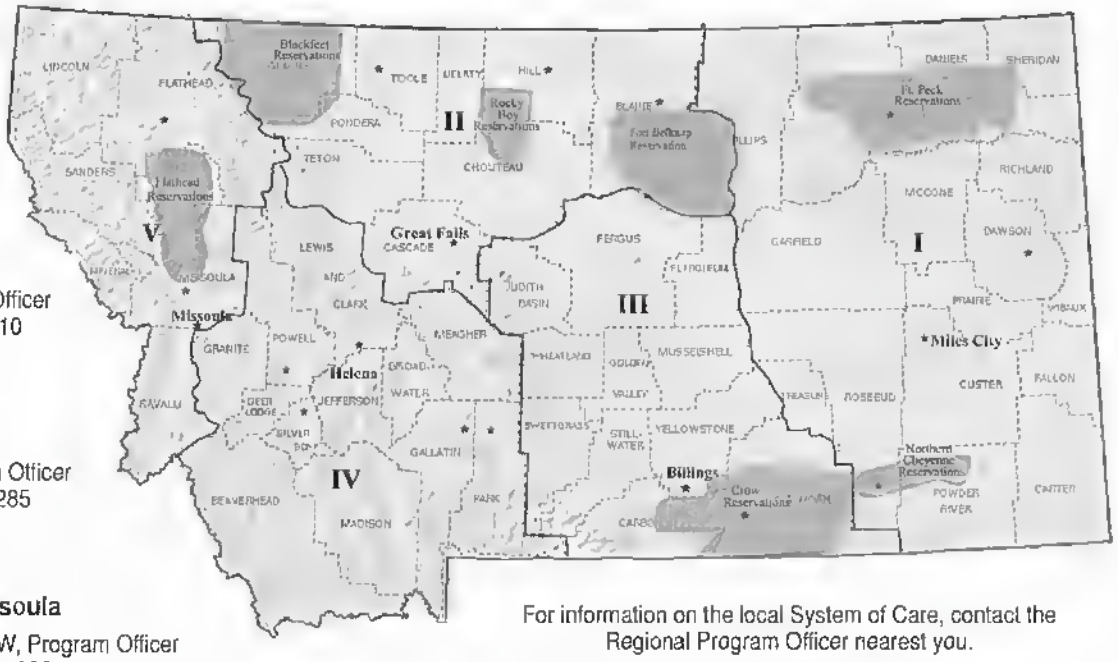

For information on the local System of Care, contact the Regional Program Officer nearest you.

A New Kid on the Block: *the Helena KMA*

—Rita Pickering

Region IV of the Children's Mental Health Bureau covers 12 counties, from Lewis and Clark County to the southwest border in Beaverhead County and Yellowstone Park. Four Kids Management Authorities (KMAs) are active in this Region.

So far, the Helena KMA has served about a dozen youth and their families. The KMA's focus is to provide as much support as close to home as possible. To date, all of the youth served in this area have been from single-parent families. Although all of the youth are on Medicaid, many of the parents are not. This is problematic because a number of the parents struggle with their own physical and mental health issues. The emotional drain can be overwhelming.

Many say that they want their youth out of their home for a little while. No one has said, *I don't care* or *I give up.* We do occasionally hear, *I can't do this anymore* or *My child needs more than I can give.* Parents are also concerned about their other children. The entire family feels the impact of including a child with Serious Emotional Disturbance. The "normal" siblings often feel left out and can also become confused and angry.

Most of the parents feel alone and are in despair. That's why the other parents involved in the KMA are invaluable. They are the only ones in the room who can honestly say, *I know how you feel . . . I've been there.* They reach out and touch a shoulder, share a similar story, offer a phone number. No parent has walked out of the Helena KMA feeling judged or alone. If a KMA does nothing more than provide an safe venue for parents, we've accomplished a lot.

It's hard to describe a typical family or typical youth. Every child is in pain. Every family is struggling. All are in crisis and don't know what to do next. When parents haven't been able to keep a child safe or under control, they feel like failures. Family needs vary, but the pain is the same. Most come to the KMA fearing that they'll be judged. Our job is to support, not judge. We can't change the past. We can only look to the future and do our best to help families and children fulfill their hopes and dreams for their family.

—Rita Pickering is the System of Care Program Officer for Region 4. She can be reached at 444-1323.

Flathead Valley CITs

—Joan Schmidt

Children's System of Care: 52-2-301 MCA

The legislature declares that it is the policy of this state:

1. to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available;

2. to serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development;

3. to serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort;

4. to provide integrated services to high-risk children with multiagency service needs;

5. to contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements;

6. to increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children; and

7. to prioritize available resources for meeting the essential needs of high-risk children with multiagency service needs.

Children's needs for mental health and chemical dependency services are frequently urgent and profound. Though estimates indicate that there are approximately 1,200 youth with Serious Emotional Disturbance in Flathead County, the door to services for children without public funding or private insurance is often closed. Children of the working poor, whose families do not meet income criteria, often fall between the cracks. Service provision for these children is greatly hampered and, in most cases, unavailable. Professionals who identify these youth, often in a school setting, find themselves in a position of waiting for a dramatic increase in the severity of the problem so that services can be provided through other means, such as child protective services or the juvenile justice system. For these reasons, in 2001, the Flathead Valley community decided to find a way to intervene earlier in the lives of children who do not qualify for public funding.

Early intervention can save lives and dollars. Our State should work to provide a full continuum of care to all children.

During the past six years, the Youth Service Network, a nonprofit organization, has promoted the coordination of integrated multi-agency services for youth with emotional and/or behavioral disturbance and others considered to be at risk. The network facilitates the exchange and sharing of information, resources and training to improve care and treatment for youth of the Flathead Valley. This collaborative union included all of the agencies that work with at-risk youth, from Child and Family Services, to the youth justice and corrections systems, developmental disability services, mental health, chemical dependency, school districts and private providers.

The network implemented Child Information Teams (CITs) that include interdisciplinary representatives who gather to strategize and plan for the needs of an individual youth. The CITs facilitate the exchange and sharing of information so that one or more team members can serve the needs of the child. Professionals jointly create plans and deliver community-based, child-centered, family-focused treatment using integrated and coordinated funding.

The Child Information Team Agreement was signed in 2002 by all of the partnering agencies. This agreement enabled the Flathead Community to call and conduct meetings to plan for timely and effective interventions for youth who appear to be at-risk for out-of-home, school or community placement. The Kids Management Authority was formed in 2005. The KMA includes the decision makers from partnering agencies. The passage of Senate Bill 454 in 2001 and Senate Bill 94 in 2003, combined with State efforts to enhance and improve the System of Care, supported the local collaboration. A KMA is convened when barriers—such as lack of funding or lack of local treatment options—are identified.

CIT members signed a Memorandum of Understanding to work with the State in improving the comprehensive, integrated and coordinated continuum of services for multi-agency youth and their families in 2004. The Kids Management Authority of Flathead County was formed as an arm of the Youth Service Network in 2005, working through the established infrastructure of the Youth Service Network and the Child Information Team.

Our focus is to assist children and their families. The network has been diligent about cross-system training, conducting monthly educational meetings, maintaining a website, publishing a monthly newsletter and calendar of events, and providing information and forms for Child Information Teams. The network director works with other local coalitions to promote health, reduce the stigma of mental illness and help ensure early identification of mental illness and/or chemical dependency.

Success takes collaborative effort. The network's resounding success has taken years of development. As a result, we are fortunate to have a complete, effective and well coordinated Continuum of Care in the Flathead Valley.

—Joan Schmidt is the Director of the Youth Service Network. She can be reached at 406-871-1008 or jschmidt06@centurytel.net.

Trauma in Children

—Kerrie Wheeler, LCPC

One of the most common reasons for trauma in children isn't video games or R-rated movies. It is real violence perpetrated against them, their siblings or a parent by a trusted adult. Every day, in every community, thousands of children are victimized by or witnesses to violent crimes that occur in the place we hold most sacred—the home.

Many adults fail to recognize trauma in children. Teachers, ministers, childcare providers and many other professionals who work with children receive little or no training on how to assess a child's behavior for evidence of trauma. We typically require training that will help professionals, parents and caregivers recognize signs of physical and sexual abuse, but little is ever said about how to recognize that a child is living with a terrorist who holds the family hostage to his or her (not all abusers are male) demands for power and control.

Children who live in homes with domestic violence are more likely to experience clinically significant depression and/or anxiety than children who live in homes where there is no violence. These children tend to struggle with a higher incidence of learning disabilities, juvenile delinquency, suicidal ideation, eating disorders, self-injuring behaviors and a host of other problems. While physical violence is more likely to result in trauma, emotional abuse can have serious and lasting consequences to a child's self esteem, social skills, attachment and many other aspects of healthy development.

Often, behaviors of traumatized children are misinterpreted as symptoms of ADD (Attention Deficit Disorder) or as evidence of poor parenting or disciplinary strategies. Children tend to act out their experiences of trauma by re-enacting it—either as the perpetrator or the victim. They may become bullies or chronically victimized by bullies. They often develop somatic complaints—headaches, stomachaches, hives or other stress related symptoms that affect their physical well-being. Often, children struggling with domestic violence issues are sleep deprived—either because of late-night battles or the fear of one. They are often afraid of the dark and many complain of seeing or sensing the presence of ghosts. Some will describe other auditory types of hallucinatory experiences in which they hear evil or scary voices that threaten to harm them or someone they love.

Abusers frequently control their victims by threatening to harm—or actually harming—the children, including threats of kidnapping and murder. Even when there is no physical violence present, these threats have a significant impact on children, especially young children. Another means of control used by abusers is violence towards pets. Children will often report the loss of numerous pets that died or ran away, intensifying their trauma with an overwhelming sense of grief and loss.

We hear about war veterans, survivors of natural disasters and victims of violent crimes. We hear about how their experiences have traumatized them and made it difficult for them to function in their daily lives. No one is particularly surprised when a soldier returns from combat and has become a stranger to his family as a result of how the experience of war has changed him. We sympathize with the college student who drops out because she cannot cope with the daily reminder of a rape that occurred on campus or at a fraternity party. As a society, we respond to these trauma victims with support and empathy. We send money to victims of natural disasters. We volunteer our time to rape crisis phone lines. We send care packages to soldiers we've never even met, hoping to make a difference and to ease their suffering.

What are we willing to do for children who spend their entire childhood in a secret war zone that is their family?

—Kerrie Wheeler holds Masters degrees in Human Services and Counseling. She is a child and family therapist, specializing in childhood trauma and domestic violence. She has more than ten years experience working with families who have children with special needs, and has spent the last five years as the Children's Advocacy Program Director at the Friendship Center, in Helena, Montana.

Not all children who witness violence will suffer from Post Traumatic Stress Disorder or PTSD, as it is more commonly known. Children are naturally resilient and often recover from trauma more quickly than adults. In order to diagnose PTSD, a therapist must be able to document clinically significant symptoms and impairment of functioning that has persisted for 30 days or more.

—Kerrie Wheeler

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Crisis Counseling at Bozeman High

—Godfrey Saunders and Pat McCoy

Bozeman High School has a full-time Crisis Counselor on staff, which is still a relatively uncommon practice in Montana. Public high schools normally have guidance counselors, and while many are adept at dealing with crises, most of their time is committed to academic tasks. There isn't much time left over to deal with kids in crisis.

All of us—teachers and administrators—try to be highly visible and accessible. We speak to kids in the halls, stand in halls during class changes, are there to greet them before and after school. We try to do our best to be noticed. The greatest part of the job is having the opportunity to interact with teachers and kids, to celebrate the great times and work together through the hard ones. But there are about 1,850 students at Bozeman High School, and another 90 or 95 at the Alternative School. That's a lot of kids to reach.

> ***In every child, there's a great human being waiting to get out. The best we can do is show them hope and teach them that they can make it. It takes time, patience and caring. It takes thinking outside the box and taking risks...but ultimately, you have to realize that what we do as educators can never be more important than the people we serve.***
>
> **—Godfrey Saunders**

This became very evident in Bozeman several years ago, when the city lost seven students over the course of a year and a half. Two were accidents, and five were suicides. This underlined a fact that had become painfully obvious: many of our students bring serious and pressing needs with them into the school environment.

The urgency of student need is not unique to Bozeman. Demographics within schools across the country are changing. Due to a variety of circumstances, kids come to us with far greater needs than we were previously trained to deal with or had been accustomed to. There are now homeless kids in every school. We see a lot of depression, brought on by any number of things . . . divorce, death of a friend or family member, academic failure, troubles with peers. Eating disorders are more common than one would think. We have cutters and kids who are actively suicidal. And issues around drug and alcohol abuse have been with us throughout time.

After the suicides, we polled students to ask what they needed. They requested someone they could talk to, someone who would be there for them. We agreed. It was time to create a position specifically geared to providing a way to address student needs. At the end of the day, we can't afford not to take this seriously: students' lives were at risk. Our dedicated Crisis Counselor takes a clinical focus and is available to students on-site. Thankfully, we have not had a suicide since she came on.

Sometimes the Crisis Counselor will see as many as 17 kids in a day, but typically, she'll see seven or eight. The job involves balancing multiple tasks—seeing the youth, taking phone calls from parents, working with teachers, and making or receiving referrals. This job requires a lot of focused attention, clinical expertise and flexibility.

Typical behaviors that come to the attention of the Crisis Counselor include cutting, suicidal ideation, depression, self-image problems, eating disorders and disputes with peers and parents, with depression by far the most common. The number of depressed girls is approximately double the number of boys, but their symptoms are very similar.

Cutting has become increasingly common, and often goes hand-in-hand with an eating disorder. This has typically been more prevalent among girls, although lately we've seen more boys engaging in it. Cutting can take a number of forms, from eraser burns and scratches made with paperclips to cuts made by razor blades. Some will carve words in their skin. Girls often wear wrist bands or bracelets to cover the scars, but if they're on their arms, we'll notice.

Peer issues in this age group are always difficult. In high school, friendship

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There need to be more resources for kids. Many just need a safe place to go, or a list to let them how and where they can access resources. Some need the basics—food, clothing, a safe place to sleep. We have too many kids who are out there struggling and we lose them. I can't keep track of all of them, and if they leave the system, it's very difficult to find them again. We have to look at the whole person, and make sure we have resources in place so that these kids don't lose hope.

—Pat McCoy, Bozeman High Crisis Counselor

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Crisis Counseling

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groups are all important. In a school this large, there are cliques everywhere. If kids aren't readily accepted, or if the peer groupings suddenly change, they find themselves adrift. Cruelty at this age is not uncommon, and being ostracized or the subject of rumors can be devastating.

When a student comes in, we make it very clear from the outset that the Counselor will talk to parents or other professionals as appropriate if there's a threat to self, a threat to others, or if there's abuse that hasn't been reported. If there's a reason to call the parents, kids are welcome to sit in the room during the call.

For the most part, parents want the best for their kids. They send us the best they have and we need to keep that in mind, as educators and community members. We have an obligation and a responsibility to do our best as well. Especially for students at extremely high risk, we try to get parents on board immediately, and try to ensure that as many resources as possible are tucked around the child. This can include getting permission to let teachers know that there's a problem so that they can be more understanding and flexible. Kids are often relieved when their secrets get out, because suddenly they have resources to help them interrupt what's going on and to help them reach toward solutions.

Schools have come a long way in how they deal with crises—we have programs in schools we didn't have even a few years ago. Schools do a lot to meet the varying needs of students. Teachers and counselors are very good when it comes to knowing their students. Several have been trained to do initial assessments on kids, and all are good about making referrals. Crisis counseling—in a nutshell—has given us a resource to help more students make it through the school day, the month, the year . . . and to ultimately become productive citizens.

—Godfrey Saunders has been the Bozeman High School Principal for ten years. Mr. Saunders is also a member of the Montana Board of Crime Control. He can be reached at GSaunders@bozeman.k12.mt.us.

—Pat McCoy was the first Bozeman High School Crisis Counselor. Ms. McCoy can be reached at: pmccoy@bozeman.k12.mt.us.

ECD as Economic Development

There's no magic bullet to economic development, but economic research strongly suggests that a key ingredient to economic growth is investment in human capital.

Arthur J. Rolnick is Senior Vice President and Director of Research at the Federal Reserve Bank of Minneapolis and an unlikely advocate for early child development (ECD). He took a definitive look at interventions using high-quality ECD programs with at-risk children and at research on brain development. The research demonstrated that if done right, high-quality, parent-focused ECD programs that begin at birth make an extraordinary difference in outcomes for children and society.

To do it right means that ECD programs must incorporate master level teachers, regular home visits and focus on parents. Children exposed to ECD are much *less* likely to be retained in the first grade, need special education or commit a crime. They are much *more* likely to be literate by the third grade, complete high school, get a good job and raise a family. Related studies confirm dramatic improvement in at-risk children's outcomes within three or four years.

The annual rate of return on money invested in high-quality ECD programs for at-risk children was 16 percent, inflation adjusted—12 percent of that was a public return because of the reasons mentioned above. Hands down, this beats the return generated by conventional economic development.

For more information, visit: www.childrenofthecode.org/interviews/rolnick.htm

Great Websites

http://gucchd.georgetown.edu/index.html
A division of Georgetown University's Department of Pediatrics, the Center for Child and Human Development focuses on social issues affecting children, families and individuals with disabilities of all ages

http://systemsofcare.samhsa.gov/OtherAssistance/ntaccmh.aspx
The National Technical Assistance Center helps create and apply collaborative solutions to improve the social, emotional and behavioral well-being of children and families.

www.iffcmh.org/index.htm
Iowa Federation of Families for Children's Mental Health is a statewide advocacy organization working toward a seamless system of care.

http://mentalhealth.samhsa.gov/child/childhealth.asp
Child and Adolescent Mental Health

www1.nmha.org/children/children_mh_matters/promoting.cfm
Promoting Children's Mental Health

http://nccp.org/pub_ucr06b.html#6
Children's Mental Health: Facts for Policymakers.

www.nimh.nih.gov/healthinformation/childmenu.cfm
Gives a quick rundown of mental illnesses and some links to related information.

Native H.O.P.E.

Youth Suicide

The Montana Youth Risk Behavior Survey (YRBS) was conducted in February 2005, with 9,178 7th and 8th grade students and 10,259 high school students participating. This represents approximately 38% of all 7th and 8th grade students and 21% of all high school students in Montana.

– Suicide is the second leading cause of death among Montana youth ages 10-24.

– It is the leading cause of preventable death for ages 10 to 14.

– While the rate of youth suicide in Montana has declined over the past decade, it is still nearly twice the U.S. average.

– In the 12 months prior to taking the 2005 YRBS, 15 percent of 7th and 8th graders and 18 percent of high school students considered suicide.

– Twelve percent of 7th and 8th graders and 10 percent of high school students reported actually attempting suicide in the 12 months prior to the survey.

Numerous strengths, or protective factors, exist in Indian cultures and communities, including spirituality and strong extended families. Because of the extended family concept, numerous adults, community and spiritual leaders are available to take part in ensuring healthy opportunities for youth. Strong traditional values, self-reliance and the sense of pride and identity that come from tribal history and cultural activities also serve as protective factors.

Meeting any child's health and mental health needs means considering the child and the family holistically. This means taking physical, mental, emotional and social aspects of a child's life into account. American Indian families and youth face unique challenges—and have unique opportunities—rising from their history and cultures. To properly serve Indian youth, communities need to understand the effect of history on current American Indian societies, and to have a deep sense of cultural awareness reflected through any services provided.

One tremendous threat is suicide. Montana has ranked among the top five states with the highest rates of suicide for the past twenty years. Suicide is the leading cause of preventable death for ages 10 to 14 and the second leading cause of death for ages 15 to 24 and 25 to 34.

Specific cultural factors for Native American communities contribute to suicide rates for this population. National Center for Injury Prevention and Control data revealed twenty Native American deaths by suicide out of a statewide total of 175 suicide deaths in 2004. CDC data also indicates that Native American males aged 20 and older are four times more likely to commit suicide than their female counterparts. Many factors play into this epidemic, including the intense historical and social disruption of tribal cultures. Suicide can also be the result of long-standing mental health issues that include feelings of loss and grief, depression, adjustment disorder and separation anxiety.

The joy of seeing the Native youth learn, grow and begin to heal is the reward and satisfaction of being part of the Native H.O.P.E. curriculum process.

The Native H.O.P.E. (Helping Our People Endure) curriculum and workshops are providing Native American youth and adults throughout the state with the leadership skills they need to prevent this tragedy. The Native H.O.P.E. process begins with a full-day training session for adult facilitators, followed by a two-day intensive workshop for students.

The Native H.O.P.E. curriculum was presented recently at the Absaalooka Center in Crow Agency, Montana. Circle of Life Youth Wellness Community Development Specialist, Ernest Bighorn, assisted tribal administration, school personnel and a number of spiritual and community leaders from the Crow Nation with planning and organizing the workshop. Ultimately, 43 adults and 55 students participated.

The one-day *Train the Facilitator* module taught adults the skills needed to guide youth through the workshop, as well as to replicate the curriculum in their communities. The ultimate goal is to strengthen the capacity of American Indian/Alaska Native/First Nations teens and young adults to help each other, their families, schools and communities by using their *Sources of Strength*, including culture and spirituality, to break unhealthy multigenerational cycles.

The Native H.O.P.E. curriculum uses a strength-based philosophy that takes a proactive approach to suicide prevention, wellness and leadership. The approach incorporates Native culture, ceremony, traditions, healing and humor. One of the tremendous strengths of this model lies in its dedication to empowerment. The two-day workshop creates a safe place for adults and youth to mobilize as a healthy team, with the adults serving as active role models. As youth make positive connections with adults, all come to a better understanding of—and commitment to—their communities.

The days are long and challenging, starting with an early-morning team huddle and ending with debriefing sessions. During the workshop, students create strategic action plans that have great potential for reducing suicide and the many factors that contribute to it, including depression, substance abuse, violence and exposure to trauma. These plans will need the ongoing support and commitment of all Native H.O.P.E. participants if they are to succeed. They also plant the seeds for creating positive change in communities—

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Native H.O.P.E.

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a challenging journey that requires strength of will and spirit-driven commitment.

Youth participants at Native H.O.P.E. events become aware of their roles and responsibilities as Facilitators, Rovers and/or Clan Leaders. They gain skill in the group process and in leadership development. There are numerous team- and trust-building exercises, and students form and then name their "Clans." Clans then perform a SPOT analysis, which helps them identify Strengths, Problems, Opportunities and Threats. By the end of two highly interactive days, youth have begun to learn to face and overcome their fears and doubts—and to recognize and depend on their strengths.

Clans formed during the training held at the Absaalooka Center included *Thunder*, *Eagles Warriors Against Violence*, *Spirit Warriors*, *Dream Team*. *Native Warriors*. *Soaring Eagle* and *On-our-side Clan*. Students ranged in age from 7th through 12th grade, and boys and girls were equally represented. These youth clans identified their top four strengths: spirituality; family; culture/tradition: and sports/athletics. The collective strengths opened the doors to the top four identified opportunities: education; youth groups; suicide prevention conferences: and taking responsibility. The top four identified problems were drugs/meth, alcohol, drinking and driving and teen pregnancies. The top four threats were lack of support, no communication, peer pressure and no respect.

From this work came a mission that included: community development, cultural activities, a youth center, sports and outdoors activities, drug-free youth, youth conferences, scholarships and mentoring. Values are inherent in the identified strengths. Family was first, followed by values, culture/tradition, respect, education and spirituality.

Some of the suggestions that came from the clans will likely be used after the training. These primarily focused on ensuring that people recognize the signs of suicide, helping others, breaking the Code of Silence, being more respectful and becoming leaders.

The success of the Native H.O.P.E. workshop hinged on the incredible collaboration of a local planning committee that consisted of area schools, the Indian Health Service, the Bureau of Indian Affairs, various tribal programs and the community. Indian Development and Education Alliance (IDEA) Community Development Specialist, Ernest Bighorn, coordinated the efforts of Crow Tribal personnel and school personnel from Pryor, Lodge Grass, and various community and spiritual leaders from the Crow Nation. The Billings Area Indian Health Service and National Indian Health Service provided financial and human resources. The Crow Tribal Administration provided for the use of the Absaalooka Center, equipment and supplies. The Tribal Preservation Program offered financial assistance. Many spiritual and community leaders offered support and active leadership, and Dr. Clayton Small was brought in to facilitate the curriculum. These collective contributions culminated, as they were intended to, in empowered youth, closer communities and improved inter-generational communication.

> ***The culmination of the work was a Vision of Five Bold Steps:***
>
> 1. ***Outreach for youth;***
> 2. ***Teamwork;***
> 3. ***Presentations;***
> 4. ***Sobriety campouts; and***
> 5. ***A youth leadership conference.***

Native H.O.P.E. events have been—and will be—held on other reservations, here in Montana and elsewhere. Montana youth who have participated will be invited and encouraged to participate in an annual statewide youth leadership conference. The skills learned and strengths recognized are designed to last. This program uses the acronym HOPE, and it is well-named. These are the kind of steps that offer real hope for the future and that encourage all of us to see our children for what they are: our most precious and sacred resource.

—Editor's note: This article is based on the generous contributions of Bill Snell, Jr., and Tina Cline of the InCare Network, Ernest Bighorn, IDEA Community Development Specialist, and Alda Bighorn, a Billings-area consultant.

Youth Suicide (YRBS data)

Youth who have attempted suicide are more likely than their peers to have used substances.

- *Montana 7th and 8th graders who have attempted suicide are more than twice as likely (42% versus 20%) than students who have not attempted suicide to have had at least one drink of alcohol in the 30 days prior to taking the survey.*
- *Montana high school youth who have attempted suicide are more likely (60% versus 44%) to have had a drink of alcohol in the 30 days prior to the survey.*
- *Montana 7th and 8th graders who have attempted suicide are over three times more likely (31% versus 9%) than students who have not attempted suicide to have smoked cigarettes in the 30 days prior to taking the survey.*
- *Montana high school youth who have attempted suicide are nearly twice as likely (41% versus 22%) to have smoked cigarettes on one or more days in the 30 days prior to taking the survey.*

Source: http://opi.mt.gov/YRBS

Treating ADHD

—Kelly Burton, Registered Pharmacist

ADHD

Is it hard for your child to sit still? Does s/he act without thinking? Start but not finish things? If so, your child may have Attention Deficit Hyperactivity Disorder (ADHD).

Nearly everyone shows some of these behaviors at times, but ADHD lasts more than 6 months and causes problems in school, at home and in social situations. ADHD is more common in boys than girls, affecting 3-5 percent of children in the United States.

No one knows exactly what causes ADHD. It does run in families, so genetics may be a factor. A complete evaluation by a trained professional is the only way to know for sure if a child has ADHD. Treatment often includes medicines to control symptoms.

http://www.nlm.nih.gov/medlineplus/

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common mental disorders that develop in children. It shows up early and is usually diagnosed before age seven. Symptoms include impulsiveness, hyperactivity and/or inattention. These symptoms must be present for at least six months *and* produce a negative impact on two or more areas of life, such as school, home or church.

Psychiatrists, psychologists, clinical social workers, pediatricians, family physicians and neurologists can all diagnose ADHD, but they can't all provide the same treatments. Psychologists and clinical social workers provide counseling and other life training skills, but cannot provide health screenings or prescribe medications. Physicians and neurologists can provide health screenings and prescribe medications, but do not provide counseling. Psychiatrists can do both. Each child is unique and it is important to pick the specialist who is best for the particular child.

When diagnosing a child with ADHD, a specialist must rule out any other causes that could contribute to ADHD-like behaviors: a sudden change, such as a death of a loved one, divorce or move; undetected seizures; learning disability; anxiety and/or depression; middle ear infections; or another medical condition that affects brain functioning.

There is no single treatment that is best for every child. Each child's needs and medical history must be evaluated to determine the best possible treatment choices. In general, the most effective treatment options tend to be a combination of therapy/counseling and medication. Therapy and/or counseling helps the child and the family gain an understanding of the disease, skills to cope with daily problems and a focus on prevention. Medications help control the symptoms of ADHD, which helps the child build from his or her skills and strengths.

For many years, medications have been used to treat ADHD. Central nervous system stimulants are the most common. They block the reuptake of the neurotransmitter dopamine, which is increased in the cerebral cortx and the brain stem arousal system. The most common stimulants are listed below, along with their FDA approved age.

- Amphetamine (Adderal)—age 3+
- Methylphenidate long acting/extended release (Concerta, Metadate ER/CD, Ritalin LA/SR—age 6+
- Methyphenidate short acting (Ritalin)—age 6+
- Dextroamphetamine (Dexedrine, Dextrostat)—age 3+
- Dextroamphetamine slow release (Focalin)—age 6+

Treating ADHD with stimulants is considered to be quite safe. Common side effects include decreased appetite, increased anxiety, headache, stomach ache and irritability. Finding the best treatment for a child can mean trial and error. Medications should show behavioral improvements within seven days. If no improvement is shown during that time, the dose may be increased. If there is still no improvement, another medicine should be tried. Although lack of response to one stimulant does not predict the response to others, about 10 percent of children do not benefit from stimulant.

Once a medication has been prescribed, it is important never to administer additional medicine, including herbal products and over-the-counter (OTC) medications without consulting the physician or pharmacist. Herbal products such as gurana can increase irritability and anxiety. Products like Prilosec, Pepcid, Zantac, Tums and Rolaids can change the gastrointestinal pH, increasing the time the stimulant stays in the body. In contrast, products like cranberry juice can make the pH more acidic and speed up elimination of the drug.

Medication is not a cure for ADHD, but it can help control symptoms. Behavioral therapy and counseling are highly recommended for children who have ADHD, and for their families. Once behavior is stabilized, there may still be feelings of frustration, anger or blame. Counseling can help provide the skills to cope. Those with a good understanding of the disease can be better prepared, ultimately resulting in higher self esteem, self confidence and a better overall attitude.

Antidepressants and Youth

—Kelly Burton, Registered Pharmacist

Over the past couple of decades, our awareness of childhood and adolescent depression has increased. One of the warning signs for all ages is withdrawal from activities that were previously sources of enjoyment. Younger children will also tend to cling to parents, pretend to be sick and to worry. Older children or teens may also become rebellious and/or develop negative attitudes, which can result in trouble at school or with the law. Although it is typical for all children to go through phases, when depression is present, the behaviors are persistent and long-term. Psychotherapy is often the initial treatment for depression. The therapist will evaluate the severity of the disease and a treatment plan. Psychotherapy helps the patient recognize negative thoughts and feelings.

A child may be prescribed medication to help manage the depression. The use of selective serotonin reuptake inhibitors (SSRIs) has increased over the past decade. SSRIs enhance the actions of a mood neurotransmitter called serotonin at the neuronal membrane. An increase in serotonin is directly related to elevated mood.

Fluoxetine (Prozac) is the only FDA-approved mediation for young children (ages 8 and older) who are depressed. Other SSRIs have not been FDA approved, but are used on an *off label* basis. *Off label* prescribing can be beneficial to some patients, but the risks and benefits must be discussed with the health care professional. The most common antidepressant medications prescribed to young adults (aged 18+) are: Venlafaxine (Effexor); Fluozetine (Prozac); Nefazodone (Serzone); Bupropion (Wellbutrin); Sertaline (Zoloft); and Paroxetine (Paxil).

On October 15, 2004, the FDA directed all manufacturers of antidepressants to include a black box warning detailing the risk of suicide among pediatric patients. The black box warning is the most strict warning the FDA gives. A patient medication guide (*MedGuide*) must accompany all prescriptions for adolescent depression. The *MedGuide* covers factors for consideration when a child has been prescribed an antidepressant, including the risk of suicidal thoughts or actions, benefits and risks, and behavioral red flags.

Once treatment with an antidepressant medication has started, it should not be abruptly stopped. The cold turkey approach to antidepressants can lead to relapse that can be even worse than the initial stages of depression. Working with a healthcare professional and tapering off of the medication is highly recommended.

SSRIs tend to cause mild, temporary side effects, usually in the first week or two of therapy. Benefits are typically not noticed until the second week. As the dose is increased, the side effects can reoccur. The most common side effects include headache, nausea, flushing and insomnia. These usually are short term.

Parents should contact the prescribing professional if the following side effects occur: panic attacks, severe anger, aggressiveness; palpitations; flu-like symptoms with chills and aches; seizures; hives; difficult breathing; suicidal thoughts or actions. The risks of suicidal actions may be especially high among children and teenagers who have bipolar disorder, a family history of bipolar disorder, or a personal or family history of suicide attempts.

SSRIs interact with other medications, both over-the-counter (OTC) and prescription. It is important to check with the health care provider before administering another medication. Taking another type of medication that increases serotonin (e.g., migraine medications or herbal products like St. John's Wort) can lead to a sometimes fatal condition known as Serotonin Syndrome. The symptoms include tremors, fever, diarrhea, hypertension, confusion, hallucinations and even respiratory failure.

Depression is a serious medical condition and should be treated on an individual basis. Antidepressants can contribute to significant improvement, but it is critical to know and understand the potential risks and benefits.

Danger Signs

Contact your child's healthcare provider immediately if your child is taking an antidepressant and begins to exhibit any of the following signs for the first time, if they seem worse, or if they worry you, your child or the child's teacher.

- *Thoughts about suicide or dying*
- *Suicide attempts*
- *Worsened depression*
- *New or worsened anxiety*
- *Feeling very agitated or restless*
- *Panic attacks*
- *Insomnia*
- *New or worsened irritability*
- *Acting aggressive, angry or violent*
- *Acting on dangerous impulses*
- *Extreme increase in activity or talking*
- *Other unusual changes in mood or behavior*

Source: Medication Guide About Using Antidepressants in Children and Teenagers.

What About the Parents?

—Nancy Farrar

This question is heard often in the children's mental health arena. It is asked when a clinician sees a child in his office for the first time . . . and by school personnel when behavioral or academic problems come to the attention of a teacher or playground attendant. It is asked by social workers when they are investigating an allegation of abuse and neglect and by medical personnel when parents bring in a child because of behavioral or developmental issues. And finally, it is asked by System of Care officials as they work to develop a delivery system for mental health services.

Currently, the focus of the developing System of Care in Montana is Medicaid eligible children with an SED diagnosis. Families of these children are struggling with poverty issues that can include caregiver mental illness, substance abuse, domestic violence and histories of abuse and neglect. But how do we help these parents become involved in the treatment process to help their children? How do we bring parents into the mix to help design and operate under the core values of a system of care (child-centered, family focused, community based and culturally competent)?

The answer, of course, is to get to know, understand, support and build relationships with parents and to find out what they need and want for their children. This will not happen in a two-hour interview or even in several interviews. This is a process, and it occurs over time.

Nationally, interviews with parents over the past five years have consistently mentioned several factors affecting successful involvement of families. First, families report that when medical, financial and other basic needs are met, they have enough surplus energy and mental fortitude to address their child's emotional and behavioral needs. Nonclinical services such as transportation, respite, adequate housing and home safety, conflict resolution and stress reduction were some of the services mentioned as most valuable. Being able to provide opportunities like sports, music or access to other creative outlets helped parents feel they were providing something positive to their children.

Parents also stated that they became more fully connected when the provider's values included a commitment to the family and a belief that the family could achieve success. Families stated when they observed this commitment, it helped them believe in themselves. Provider dependability and honesty were also viewed by parents as characteristics necessary to help them make the decision to get help.

Factors that encouraged youth to take ownership of their treatment included having a stable and reliable support system, access to a therapist, a calm and stable home where caregivers were consistent with their expectations and consistent with punishment when expectations were not met. Youth also mentioned the importance of being allowed to be a kid. This included being allowed to participate in sports, scouting, music, art or hobbies.

Interviews with providers indicated that families who regained hope for their children and belief in the family unit had been more involved and committed in developing goals and actions in service plans for their children. These parents were more willing to examine difficult family issues, to explore and try unfamiliar treatment options, and to participate more fully in the wraparound process. Providers also witnessed an increased willingness of parents to ask for help with difficult situations, which resulted in earlier intervention and more effective treatment.

As providers, we must take the lead and listen to what families and youth have been telling us. We must incorporate their wishes in our service array so that we are able to say, with confidence and compassion, that we can answer the question, *What about the parents?* Knowing the answer to this question brings about a partnership between parent and provider in which each shares the same vision of success stated by one parent: *I want my children to find their niches. I want them to use their strengths, manage their own behaviors, contribute to society and find a place where they can shine.*

—Nancy Farrar is the Assistant Director of the Family Support Network and a graduate of Eastern Montana College. She is the single mom of three daughters, one of whom suffers from depression and one of whom has a mild learning disability.

Tribal Justice and Safety

An online resource developed specifically for Indian country has been launched by the U.S. Department of Justice (DOJ). The website provides a user-friendly, current and comprehensive resource for American Indian and Alaska Native Tribal governments to enhance the safety of their communities. It also is designed to assist the general public and other Federal agencies in learning more about Tribal justice and safety issues.

The website features educational materials addressing the relationship between the federal and tribal governments, current DOJ initiatives and activities, and numerous tribal justice and public safety resources. The site provides funding resources, grant opportunities and management information, civil rights laws and other key documents. See: www.tribaljusticeandsafety.gov/

Lessons Learned: *Dealing with mental health crises in Helena*

—Elaine Bruce and Liz Moore

In recent years, communities throughout Montana have experienced a decrease in available psychiatric beds, leaving mental health and medical providers few options for patients who require secure psychiatric care. Montana's dilemma mirrors a national decline. As beds in hospitals decrease, communities are struggling to increase free-standing beds that allow sufficient intensity of care to safely keep patients in their home communities.

In the Helena area alone, over 850 individuals in the throes of mental health crises present every year at the local emergency department. While some individuals are sent to other out-of-area, secure psychiatric treatment centers in Great Falls, Missoula, Kalispell or Billings, most end up at Montana State Hospital (MSH) because there are no secure local psychiatric beds. The primary purpose of MSH is to serve acutely ill persons who fail to stabilize within short-term acute and sub-acute care settings. This is an appropriate setting for some, but for others, it is not.

Service gaps currently impact the county and city law enforcement officers who often serve as the first responders during a crisis. They often transport individuals to facilities for evaluation and stabilization. In Helena, concerns escalated to the point that, almost two years ago, community stakeholders from Lewis and Clark, Broadwater and Jefferson counties gathered to declare, *enough is enough*.

A Tri-County Mental Health Crisis Response Partnership Project and Steering Committee was formed by the Lewis and Clark County Commission to provide leadership in improving crisis services. Rocky Mountain Development Council, Inc. (RMDC) was designated the lead agency. Subsequently, RMDC received a grant from the Montana Department of Public Health and Human Services Addictions and Mental Disorders Division to begin establishing an adequate mental health crisis delivery system in the tri-county area.

The four major objectives of the grant were:

— Create a Tri-County Mental Health Crisis Response partnership with funding and oversight responsibilities shared by Lewis and Clark, Jefferson and Broadwater counties.

— Operate a non-secure crisis stabilization facility that meets state licensure standards.

— Create a Mobile Crisis Response Team to provide professional mental health assistance 24 hours a day, 365 days a year throughout the tri-county area.

— Establish a detailed plan (including site identification, construction costs, operating costs and revenue sources) for a psychiatric inpatient facility that can provide secure, intensive, local treatment.

Since the grant was funded almost a year ago, the Partnership Project has made several significant gains. A non-secure crisis program opened in June 2006 and is operated by the Center for Mental Health, the local community mental health center. A mobile Crisis Response Team began operations in March 2007. The Crisis Response Team (CRT) is staffed by three full-time therapists who rotate on an on-call basis. They provide immediate assistance to medical and law enforcement personnel who are working with those in mental health crises. The remaining objective, by far the most challenging, involves developing a sustainable local facility with sufficient secure psychiatric beds to serve the tri-county in the years to come. Securing ongoing funding for the array of crisis response services continues to be a priority.

The list of lessons learned through this process is short but significant.

1. It is key to diligently research, identify and prioritize the needs of the community in order to address the most significant concerns. Being responsive to the community increases buy-in and broad-based ownership, allowing a diverse group of stakeholders to create common goals. It is also important to look toward the community's future, not just the needs of today.
2. Look for as many blended funding sources as possible in order to create sustainable services. It's not possible to meet the wide array of community needs by focusing just on Mental Health Services Plan and Medicaid funding. Programs, facilities and staffing patterns have to pass muster for public and private funding to ensure the broadest possible funding base.
3. Stakeholders must stay community- rather than provider-focused. Successful projects bring together public and private health providers, law enforcement, mental health providers, consumers and advocacy groups who together develop services to address funding concerns while meeting the needs of those who have mental illnesses.
4. Developing mental health crisis response services is a process. Events happen along the way: funding is received, partnerships are formed, facilities are located and staff is hired. The overall system, however, continues to evolve. In that light, it is important to understand and respect the dynamics of change. By communicating, defining and respecting parameters and recognizing the tension provoked by change, partners can avoid territorialism. When this happens, partners are able to solidify around common aims and do more together than they could have ever hoped to do as single entities.

Helena is far from unique in its search for an array of community mental health services that includes locally based intensive crisis care. For more information on the process undertaken by Rocky Mountain Development Council, contact Elaine Bruce, Manager, Mental Health Project at EBruce@rmdc.net or Liz Moore, Communications Coordinator at LMoore@rmdc.net.

Tobacco and Mental Health I

—Dr. Robert Shepherd

What is the relationship between nicotine (tobacco) addiction and mental health? There are a couple of possibilities. Perhaps tobacco predisposes to mental health. Perhaps tobacco (nicotine) is a form of self-medication. But does smoking cessation help those suffering from mental health or is it a distraction from their other problems?

Let's look at three mental health problems, starting with depression. Studies have looked at groups of teenagers: those who smoke, but have no evidence of depression; those who don't smoke but do have mental health problems; and those who do smoke, but are not depressed; and those who smoke but are not depressed. Among those who smoked but had no evidence of depression, the risk of developing depression over the next year was two to three times higher than it was among those who don't smoke. Smoking doubles or triples the risk of a teenager becoming depressed over the next year. This doesn't indicate a direct correlation—we can't say that smoking causes depression. It does imply that if we could prevent smoking in teenagers, we would dramatically reduce their risk of developing depression. And this means fewer people suffering from that disease.

Among those who smoked but had no evidence of depression, the risk of developing depression over the next year was two to three times higher than it was among those who don't smoke.

What about people who don't smoke but who are already depressed, as compared to people who don't smoke and are not depressed? Do depressed teenagers start smoking at greater rates? (This is the *self-medication* theory.) This doesn't seem to be true, or if it is, it is a very mild effect. Those who are already smokers may increase their tobacco use, but it doesn't seem to be a very strong motivation to start smoking. So the *self-medication* theory has little support, at least for depression.

Does smoking cessation help improve depression in people who smoke? We don't have a direct answer to this question, but in one study, former smokers reported a much lower incidence of depression and suicidal thoughts as compared to their counterparts who continue to smoke. This strongly implies that smoking cessation can benefit people suffering from depression.

In one study, adolescents who were smoking by age 14 were six times more likely to be charged with drunk driving by age 30 than their nonsmoking peers.

There is less evidence on the impact on anxiety disorders. What is striking is that the risk of developing anxiety disorders is 5 to 15 times higher in smokers than in non-smokers. This strongly implies that we are dealing with the same phenomenon here as we are with depression. Some adolescent smokers report that with their first cigarette, they felt relaxed. This sensation was strongly correlated with developing tobacco addiction. We have not found any studies on the impact of quitting tobacco on anxiety disorders.

In one study, adolescents who were smoking by age 14 were six times more likely to be charged with drunk driving by age 30 than their nonsmoking peers. Tobacco may indeed be the gateway drug. Teenage smokers have higher risks of developing problems with alcohol, marijuana and cocaine. This also points to tobacco's role in the development of subsequent additions.

In a last example, smoking in adolescence doubled the risk of schizophrenia. Up to 95 percent of people with schizophrenia smoke. Since we lack even a basic understanding of this disease and its alteration of brain functions, it is hard to draw firm conclusions at this time. There is interesting evidence on the impact on nerve cells involved in hearing (auditory neurons) and auditory hallucinations in schizophrenia. Nicotine exposure in utero may alter auditory neurons, creating a predisposition to auditory hallucinations. Nicotine use in schizophrenia may reduce these hallucinations. Many medications used for schizophrenia do not improve auditory hallucinations, but two new medications that do reduce them seem to correlate with reduction of smoking behavior in people with this disease. This is all very preliminary information, but perhaps it will lead to a much more profound understanding of this disease.

In conclusion, there is one last point that is important to make and make strongly. Having a mental illness does *not* protect you from the well-known and harmful effects of tobacco use. Heart disease and cancer are more common in people with mental illness partly—or mostly—because of their increased use of tobacco. Moreover, people with mental illness can quit. As it is for everyone else, it is hard for people with mental illness to quit. But with help, consideration, medication and strong recommendations from counselors, physicians and families, people with mental illness can quit smoking.

To take the position that people with mental illnesses have more pressing problems to deal with is to regulate a whole segment of the population to shortened lifetimes and more health problems. This is a singularly pernicious form of discrimination.

Tobacco and Mental Health II

—Dr. Richard Sargent

Dr. Shepard made the point that smoking is common among the mentally ill. In institutional settings, more than 70 percent of the population smokes, while in community settings, the incidence of smoking among the mentally ill is closer to 50 percent. To put this in perspective, consider that in one study, persons with mental disorders smoked 44.3 percent of *all* cigarettes smoked by a representative sample of Americans (Lasser, Karen, et. al. 2000). Additionally:

- People diagnosed with bipolar disease are almost twice as likely to attempt suicide if they smoke (Ostacher, Michael, 2006).
- Adolescents who smoked heavily were 6.8 times more likely to develop agoraphobia, 5.5 times more likely to develop generalized anxiety disorder, and 15.6 times more likely to develop a panic disorder than their counterparts who smoked fewer than 20 cigarettes a day or not at all (Johnson, J.G., 2000).
- People with mental disorders developed cancer earlier and had twice the risks of primary brain tumors and one and a half times the risk for lung cancers (Carney, C.P., et. al., 2004).
- Patients diagnosed with Bipolar Disorder are more than twice as likely to have major medical illnesses and to get them at a younger age than the "healthy" population (Carney, C.P., and Jones, L.E., 2006).

The association of smoking preceding mental illness has also been found for Post Traumatic Stress Disorder (PTSD), bipolar disorder and schizophrenia. In March 2007, Dr. Leslie Jacobsen published a study in *Neuropsychopharmacology* showing that the incidence of Attention Deficit Hyperactivity Disorder (ADHD) increases after the onset of parental smoking. This effect was most pronounced among children whose mothers smoked during pregnancy.

The evidence is overwhelming: the mentally ill have a markedly increased risk for premature chronic illness and death. A significant reason for this is the amount of nicotine addiction among this population, but secondhand smoke also plays a part. Thankfully, in Montana, hospitals and inpatient centers have been required to go smoke-free. Imagine the amount of secondhand smoke this population would be exposed to with a 70 percent prevalence rate of smokers.

Former smokers see their risk of depression drop when they stop smoking. The risk continues to drop for years.

We understand a great deal about the effects of smoking and secondhand smoking on most major organ systems in the human body, but we are just beginning to unlock the effects on the brain and mental health.

Smoking has an effect on brain structure. Smokers demonstrate changes in both quantity and density of gray matter neurons in the frontal regions (anterior cingulate, prefrontal and orbitofrontal cortex), the occipital lobe and the temporal lobe including parahippocampal gyrus. Group differences of either grey matter volume or grey matter density were also found in the thalamus, cerebellum and substantia nigra.

Human beings live in the prefrontal and orbitofrontal cortex. (Hence the "cure" of a frontal lobotomy.) Emotions and reactions are controlled more in the thalamus, hippocampus, anterior cingulate gyrus, nucleus accumbens, amygdala and substantia nigra (collectively, the limbic system). Intravenous nicotine administration affects activity of the neurons in these areas. My conclusion is that nicotine decreases the quantity of nerve cells in these areas.

This is important because nicotine works in the brain like other addicting drugs. It has diffuse effects across the limbic system and prefrontal cortex and activity in these areas is associated with auditory hallucinations in schizophrenia. People with schizophrenia have decreased function in these areas when compared to normal control subjects. Schizophrenia is now being understood as a disruption of a major portion of circuitry rather than a single lesion.

We have a neuroanatomical and functional model of schizophrenia and auditory hallucinations. We have a similar model of the effects of nicotine on the brain. If we eliminated smoking, would we eliminate mental illness? No. We won't *eliminate* heart disease, stroke, lung disease or cancer, either. But it is becoming clear that nicotine abuse has a deleterious effect on mental health. And, as always, *an ounce of prevention is worth a pound of cure.*

Cannabis and Mental Illness

Brain scans showing how cannabis affects brain function may help explain why heavy consumption of the drug triggers psychosis and schizophrenia in a small number of people. Psychiatrists are increasingly concerned about the mental health impact of smoking large amounts of modern super-strength marijuana, or skunk, particularly among young people. Until now, the mechanism by which cannabis works on the brain has been a mystery, but modern scanning techniques mean experts can now detect its impact on brain activity.

Full article: www.reuters.com/article/healthNews/idUSL3026841220070430

—Dr. Richard Sargent and Dr. Robert Shepard are the Helena physicians who co-authored the landmark Helena Heart Attack Study. Together they have given presentations on secondhand smoke in 25 states. In September 2006, they received the American Cancer Society's highest award for advocacy, the Ted Marrs Award.

The Last Word

—Joan Cassidy, Chemical Dependency Bureau Chief

As we've noted in other issues, co-occurring disorders are the expectation, not the exception. Approximately 60 percent of the people served through the chemical dependency treatment system have a co-occurring mental illness. Given that, the number of children with Serious Emotional Disturbance (SED)—about one child in ten, or 20,000 statewide—provides a lot of food for thought.

There are many links between a child's risk of eventual chemical abuse or dependency and Serious Emotional Disturbance. SED disrupts the daily functioning of children at home, at school and in the community. Children who struggle in school are at serious risk of such poor outcomes as school drop-out, substance abuse, teen pregnancy and corrections system involvement. Children who cannot make healthy social connections at school or in the community lose out on a host of protective opportunities that can ameliorate the effects of personal risk factors.

The suspected causes of SED are complicated and generally thought to be attributable to a combination of biology and environment. Biological causes can include such factors as genetics, chemical imbalances or damage to the central nervous system, such as might be incurred through a head injury. Environmental factors include exposure to violence, abuse, chronic poverty, discrimination or loss through death, divorce or broken relationships. Although parental substance abuse doesn't have to play a part in any of these situations, all are commonly found in context with chronic substance abuse and addiction.

Often, children go on to replicate learned patterns, so long-term exposure to loss, violence, abuse and chronic poverty can set a child up to continue that exposure as an adult and as a parent. Without support, all can lead to outcomes that include mental illnesses such as depression or post traumatic stress disorder, and co-occurring substance abuse. When taken in context, this makes a powerful case for prevention.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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